

EQUAL OPPORTUNITIES MONITORING INFORMATION

Title	Forenames	Surname
Date of Birth		

<p>Marital Status How would you describe your marital status?</p> <p>Married <input type="checkbox"/></p> <p>Unmarried <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>	<p>Ethnic Origin How would you describe your ethnic origin?</p> <p>White <input type="checkbox"/></p> <p>Black - African <input type="checkbox"/></p> <p>Indian <input type="checkbox"/></p> <p>Bangladeshi <input type="checkbox"/></p> <p>Black - Caribbean <input type="checkbox"/></p> <p>Black - Other <input type="checkbox"/></p> <p>Pakistani <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>
<p>Disability Do you consider yourself to be disabled? YES / NO</p>	

Occupational Health
Do you suffer from any of the following disabilities or medical conditions?
(Please circle the answer to all questions)

Breathing difficulties	YES	NO
Asthma	YES	NO
Bronchitis	YES	NO
Emphysema	YES	NO
Hay fever	YES	NO
Heart (Cardiac Conditions)	YES	NO
Arrhythmias	YES	NO
Coronary blockages	YES	NO
Any Infarctions	YES	NO
Aortic Aneurisms	YES	NO
Have a pacemaker fitted	YES	NO
Diabetes	YES	NO
Epilepsy	YES	NO
Any Renal problem (Kidneys)	YES	NO
Skin Problems	YES	NO
Dermatitis	YES	NO
Acne	YES	NO
Eczema	YES	NO
Back Problems	YES	NO
Repetitive strain injuries	YES	NO
White Finger Syndrome	YES	NO
Is your eyesight good	YES	NO
Do you ever wear glasses	YES	NO
Do you suffer with any allergies	YES	NO
Are you pregnant	YES	NO
Do you suffer with stress (only if being treated)	YES	NO

Do you require any special personal protective equipment to assist and protect you or your dependants?
If so, please make a note:-